STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125062	A. BUILDING: _____ B. WING _____	09/13/2019

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HALE KUPUNA HERITAGE HOME, LLC	4297A OMAO ROAD KOLOA, HI 96756

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4 000	Initial Comments A state re-licensure survey was conducted at the facility from 09/10/2019 - 09/13/2019. The facility's census was 65 residents at the time of entrance.	4 000		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the resident was assisted to eat in a dignified manner for one of 12 residents (Resident (R) 31) observed for dining in the Mokihana unit. This deficient practice has the potential to affect all residents who require feeding assistance. Findings Include: On 09/12/19 at 08:00 AM, Certified Nurse Aide (CNA) 87 was observed standing next to R31 to feed her. The overbed table was in front of the resident with the breakfast tray atop it. CNA87 scooped small portions of the pureed egg and	4 115	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. C.N.A. 87 was educated by DON regarding proper feeding position and verification of meal being served to Resident 31. 2. Identified residents requiring assistance with meals have been audited	10/22/19

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4 115	Continued From page 1 oatmeal to feed the resident using a soft tipped spoon. R31's breakfast meal tray consisted of, "pureed egg, oatmeal, egg toast blend," per CNA87. The tray also had orange juice, water and Ensure pudding. CNA87 said, "I know the puree is not papaya. I don't know what this one," and pointed to the small cup of a beige food item. "No papaya. So if none papaya, I have to make sure I ask kitchen. We always serve papaya." CNA87 was asked if she would want to know what she was feeding the resident prior to, and she nodded yes. Yet, CNA87 did not know what one item was and that there was no pureed papaya, although it was on the diet card. CNA87 continued to feed R31, using a small soft tipped spoon. However, CNA87 stood next to R31's left shoulder facing the same direction as the resident. Thus, when CNA87 scooped the food from the tray, she had to crook her right elbow at an odd angle to get the spoon to the resident's mouth. The State Survey Agency (SA) asked CNA87 about her method of feeding the resident. CNA87 said, "No, I just stand up like this, usually I supposed to sit down." R31 has swallowing and chewing difficulties and CNA's feeding technique did not allow CNA87 to clearly look at the resident to monitor for potential aspiration. On 09/12/19 at 08:09 AM, with RN19 present at R31's bedside, she said to CNA87, "Next time bring chair over here and then make like this way and then feed." RN19 said they were staffed this morning with herself and CNA87, but a transporter, a CNA came to help serve the residents their foods. RN19 said it was always one charge nurse and one CNA, and other	4 115	to ensure proper resident and staff positioning & meal verification. 3. Facility□s Dignity: Feeding Residents and Patients form will be reviewed and revised as indicated to ensure that staff that are assisting residents with dining are positioned appropriately. Nursing staff will be re-educated on proper positioning while assisting residents during dining and proper verification of meal being served. 4. DON or designee will conduct audits on proper positioning while assisting residents during dining and proper verification of meal being served. Audits will be done weekly x4 and monthly x2 thereafter. Results of audits will be referred to the QAPI committee for review and follow up as indicated.	

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4 115	Continued From page 2 administrative staff would come over to bring the food and assist. A review of the CNA position description revealed an essential function was to provide residents with meal assistance, which included verifying the diet cards and assisting with the meals. R31 requires staff assistance for eating. On 09/12/19 at 08:27 AM, the Director of Nursing (DON) and the Chief Nursing Officer (CNO) were informed of the way CNA87 was observed feeding R31. The DON stated because R31's bed, "is pretty high," and they (staff) have to be at the resident's height, which is a standing height, . . . " The facility's, "Dignity: Feeding Residents and Patients" form did not mention whether staff should sit to feed a resident. However, the RN on duty told CNA87 to bring a chair over to sit and assist with the feeding, and to reposition herself in order to feed and observe the resident better since R31 is at risk for aspiration. The facility is responsible for providing care to residents in a manner that helps promote quality of life. This includes respecting a resident with dignity during dining. The manner in which R31 was observed to be fed was not a dignified nor safe approach for her based on her comprehensive care plan.	4 115		
4 117	11-94.1-27(6) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon	4 117		10/22/19

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4 117	Continued From page 3 request. A facility must protect and promote the rights of each resident, including: (6) The right to be informed in a language, or in a manner that the resident understands, of the resident's health status and medical condition; This Statute is not met as evidenced by: Based on interview, and Record Review (RR), the facility failed to assure the Power of Attorney (POA-authority to act for another person) of one of one residents (Resident (R) 16) sampled, was notified after R16 fell three times in a 24 hour period. R16 was receiving hospice (end of life care) services during that time, but the facility retains primary responsibility for the notification of POA. As a result of this deficient practice there is the potential that important issues/events affecting hospice residents may not be communicated to their POA or Resident Representative. Findings include: RR revealed R16 was a 77 year old who had a diagnosis of malignant neoplasm of the prostrate (prostrate cancer) and vascular dementia (caused by impaired supply of blood to the brain which may cause problems with reasoning, judgement, and memory). He had severe cognitive impairment, and was unable to make decisions for himself. R16's Family Member (FM) was his designated POA. R16 was admitted to the facility on 04/12/19 and was receiving Hospice services until discharged	4 117	1. DON contacted the POA of Resident #16 ensuring appropriate fall notification occurred. 2. Audited incidents involving hospice residents over the past 90 days to ensure that appropriate notifications were made. Appropriate follow up initiated based on audit results. 3. Education provided to licensed nursing staff regarding proper notification and follow up of incidents involving hospice residents. 4. DON or designee will conduct audits on incidents involving hospice residents to ensure their POA or Resident Representative is notified of incidents appropriately. Audits will be done weekly x4 and monthly x2 thereafter. Results of audits will be referred to the QAPI committee for review and follow up as indicated.	

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4 117	Continued From page 4 from Hospice on 07/27/19 after showing significant improvement of his medical condition. During the time he was receiving Hospice services, R16 had three documented falls with no injury, 07/04/19 at 12:30 AM, 07/04/19 at 04:55 AM, and 07/05/19 at 12:23 AM. There was lack of documentation that R16's POA had been notified by either Hospice or the facility. RR of the facility internal "Incident Reports" revealed the following documentation: 07/04/19 12:30 AM : " Notification of responsible party...Name: per Hospice they'll take care of it." 07/04/19 04:55 AM : " Notification of responsible party...Name: per Hospice they'll take care if it." 07/05/19 12:23 AM : " Notification of responsible party " Box is checked, but there is no documentation who was notified. On 09/11/19 at 01:22 PM during a phone interview with R16's POA, inquired if he had been notified by Hospice or the facility that R16 fell three times in July. POA replied, "No, I was not aware of that." On 09/13/19 at 10:22 AM during an interview with the Director of Nursing (DON), reviewed documentation of R16's three falls. The DON stated, "We did not notify (POA), because Hospice told us to stop calling the families. Hospice said they need to be the ones that contact the family. They (Hospice) did not want us to notify them anymore, and said they are the main contact. They gave us an in-service, and at that time told us not to call the families, and that they would do it." Queried if there was a policy or language in the contract that delineates that responsibility, and the DON said, "I don't think so."	4 117		

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4 117	Continued From page 5 A discussion regarding the overall responsibility of the facility for coordination of care, communication with the POAs, and monitoring of Hospice services was done. The facility did not follow their own policy. Review of the facility's policy titled, "Falls Program" directs facility staff to, "Upon an event of a fall or near fall, the nurse will . . . Notify POA of fall and findings." The facility had a contractual agreement with a certified hospice provider to provide services at the facility. The agreement states, "Hospice desires to provide hospice services to eligible Nursing Home residents in coordination with the management and staff of Nursing Home..." The contract also states, "services to be performed cooperatively by hospice and nursing home" with, "Joint responsibility" and will, "mutually establish policies and protocols for the care of the Hospice patient." There was no language in the hospice agreement regarding communication with POA's in this situation.	4 117		
4 118	11-94.1-27(7) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (7) The right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive; □	4 118		10/22/19

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4 118	Continued From page 6 This Statute is not met as evidenced by: Based on record review (RR) and interview, the facility failed to have a process in place to establish, maintain, and implement written policies and procedures regarding the resident's right to formulate an Advance Directive (AD) for four of 16 residents (Residents (R) 15, 28, 43, and 165) selected for review. This deficient practice had the potential to affect all residents' capability to formulate an AD. Findings Include: 1) On 09/11/19 at 03:00 PM, RR reflected R15 was admitted to facility on 11/27/15 with the following diagnoses: Amnesia, Essential Hypertension, Hyperlipidemia, Malignant Neoplasm of the Prostate, Unspecified Dementia without Behavioral Disturbance. No AD noted on file for R15. On 09/18/19, Administrator provided copies of documentation regarding AD for R15. The documentation is as follows: Care Conference Summary dated 11/14/18, Clinical Notes Report by Social Services dated 12/27/18, Clinical Notes Report by Social Services dated 04/05/19, Care Conference Summary dated 05/15/19, and Care Conference Summary dated 08/14/19. Review of the aforementioned documents found no mention of providing resident and/or his or her representative(s) information and education regarding AD, only that the facility is here to assist and support. 2) On 09/12/19 at 01:39 PM, RR showed R43 was admitted to facility on 08/01/18 with diagnoses of: Essential Hypertension, Chronic	4 118	1. Social Services Director provided residents #15, 28, 43, 165 and or his/her representative information and education regarding advanced directives. 2. Residents identified thru audit have been provided additional information and education regarding the right to formulate an advanced directive. 3. Current Advanced Directive Policy and Procedure reviewed to ensure that process is in place to establish, maintain, and implement an advanced directive. Administrator or designee will review and revise as indicated. 4. Per the RAI schedule resident advanced directive information, formation, and implementation of an advanced directive will be monitored by the IDT. Administrator and/or designee will review to ensure appropriate follow up. Results of review will be reported to the QAPI committee for further follow up if indicated.	

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4 118	Continued From page 7 Kidney Disease-Stage 3, Atrial Fibrillation, Hyperlipidemia, Diabetes Mellitus Type 2, Schizophrenia, Right Above Knee Amputation, Heart Failure, Sleep Apnea. RR reflected no AD for R43. On 09/18/19, Administrator provided copies of documentation regarding AD for R43. These included: Clinical Notes Report by Social Services dated 09/06/18, Care Conference Summary dated 01/02/19, Care Conference Summary dated 04/03/19, Clinical Notes Report by Social Services dated 06/21/19, Clinical Notes Report by Social Services dated 07/08/19, Care Conference Summary dated 07/17/19, Clinical Notes Report by Social Services dated 09/04/19, and Clinical Notes Report by Social Services dated 09/06/19. None of the documentation mentioned above showed that AD information and education were given to the resident and/or his or her representative(s). 3) During a RR for R28, no AD was found. A Physicians Order for Life Sustaining Treatment (POLST) states Do Not Attempt Resuscitation (DNAR) with limited interventions. Requested copy of the AD and AD Policy from the facility administrator. Clinical notes dated 01/28/19 were received and reviewed. R28's family member (FM) assumes all responsibilities and serves as surrogate for R28. FM declines assistance with updating POLST and in agreement that all forms are current. Clinical notes dated 04/19/19, 07/25/19 and 09/11/19 revealed no documentation that R28's FM was provided education about an AD or offered assistance to formulate one. The documentation is in regard to the POLST.	4 118		

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4 118	Continued From page 8 4) During a RR for R165, no AD was found. The POLST states DNAR. The Facility admission packet was reviewed at Section 4. Advance Health Care Directive and POLST. There was an initial at, "provided a copy of the Resident's advance health care directive to the Community. Durable Power of Attorney found. Family member of R165 named as power of attorney (POA) dated 07/28/06." Requested copy of the AD for R165 and AD Policy from the facility administrator. Documentation received and reviewed for R165. Durable General Power of Attorney, provided for R165 page 3, at #11. states, "consent to medical treatments: to have exclusive authority to give consent for such medical treatment to be administered, . . . " No AD found for R165 or documentation that the facility provided the information (brochure, etc.) to the POA and offered to develop an AD to the POA. During an interview with the Social Worker (SW)1 on 09/13/19 at 11:35 AM, stated that she meets with the resident or representative to go over the admission paperwork. "I show the resident or representative the form (AD) and ask if they have ever filled one out and offer to make a new one for them. If they don't have one and don't want to develop one I give them the handout. I help them complete the other section which states at what point they want treatment to stop. If they don't want an AD we follow up every three months at the interdisciplinary team meeting (IDT). If there is a surrogate we offer the same information. Most of the time they decline."	4 118		

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4 136	Continued From page 9	4 136		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observation, record review, interview and policy review, the facility failed to use a two-person assist to transfer a resident while using the hoyer lift (a mechanical floor lift and assistive device) for one resident (Resident (R) 31) selected for review. As a result, R31 sustained a significant head injury to the back of her head, which was a large hematoma (collection of blood from damage to a larger blood vessel) measuring 8 centimeters (cm) in length x 7 cm in width x 1 cm in depth and a laceration. The facility's investigation also did not determine why R31 was showered so early on the morning of 04/20/19 by the only Certified Nurse Aide (CNA) 25 working the night shift. There was no documentation of CNA25's task performed as well. This deficient practice, including the lack of adequate supervision of CNA25 by the charge	4 136	1. DON completed education with C.N.A. 25 regarding proper hoyer lift use, adherence to shower schedule, and proper documentation of C.N.A. task performance. Incident root cause has been re-reviewed to determine adequacy of prior investigation. 2. Audited through direct observation of residents requiring hoyer lift transfers to ensure appropriate equipment setup and technique is adhered to. Audited to ensure night shift showers only occur per resident/responsible party request or are necessary due to exigent circumstances and documented accordingly. 90 day retrospective review of hoyer lift related incidents was completed to determine adequacy of investigation.	10/22/19

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4 136	Continued From page 10 nurse that night, was a contributing factor for R31 sustaining serious injury and harm. This deficient practice also has the potential to cause serious harm to other residents residing in the facility, as the facility failed to complete their in-service education/training for hoyer lifts after the accident, and failed to monitor ADL activity/care provided to the residents during the night shift. Findings Include: Resident (R) 31 is an 85 year old resident who has a diagnosis of end stage dementia and is receiving comfort care. She was non-verbal, observed primarily in bed, and required staff assistance with her Activities of Daily Living (ADLs). A family interview was done on 09/11/19 at 04:45 PM, and during the interview with R31's Family Member (FM), it was revealed that R31 had fallen out of a transfer lift sustaining a head injury. The FM said R31 was taken to the hospital emergency department for evaluation and treatment. The FM also found out for R31's showers, "it was 3:30-4:00 in the morning and that was the night shift and they had been doing that for I don't know how long up until the incident anyway. Then they stopped after what happened." The FM said after R31's accident, the facility said they wanted to switch R31's showers to bed baths, but the family declined and told them to continue with the showers, "but not that early in the morning." The FM further said her understanding of R31's fall from the hoyer lift was because, "the attachments weren't attached properly." The FM said according to the nurses, she was told, "their protocol is that it should be two people. They told me this." The FM said it was the older hoyer lift	4 136	3. Education will be done with nursing staff on utilization of mechanical lift transfers and documentation of showers provided on night shift. Education will be done with IDT regarding root cause analysis of incidents. Increased communication/supervision will be facilitated through the use of mobile communication devices. 4. DON or designee will conduct audits of residents requiring hoyer lift transfers to ensure equipment setup and technique is adhered to. DON or designee will audit night shift shower documentation. DON or designee will audit ongoing hoyer lift related incidents to ensure adequacy of investigation. Audits will be done weekly x4 and monthly x2 thereafter. Results of audits will be referred to the QAPI committee for review and follow up as indicated.	

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4 136	Continued From page 11 which was used on the morning of 04/20/19. Review of R31's Minimum Data Set (MDS) April quarterly review with a 04/25/19 observation end date showed she requires a two person physical assist for bed mobility, transfer and toilet use. R31's comprehensive care plan at risk for falls and self-care deficit related to her Alzheimer's dementia and non-ambulatory status noted, " . . . fall from Hoyer lift; CTs negative for injury; Staff re-educated for proper technique for Hoyer lift." Review of a 04/24/19 "change in condition" clinical entry revealed the resident was seen for, ". . . the following acute problem of: f/up (follow-up s/p (status post) fall and ER (emergency room) visit . . . The resident sustained a fall while transferring to a shower chair. She was sent to the ER for further evaluation due to a large occipital hematoma . . . " Further review found the following: 1) The mechanical lifts, including the hoyer lift, was a two person assist to ensure safe transfer of a resident. CNA25 had received in-service education on the use of a mechanical lift prior to the 04/20/19 accident. This was verified by the Director of Nursing (DON) on 09/13/19 at approximately 12:10 PM, when she produced CNA25's 12 hour inservice education sheet. The DON confirmed CNA25 received this training on 04/08/19, which was included in their topic, Safety & Body Mechanics. Yet, it was found that CNA25 did not follow this basic safety protocol, and by performing a single person assist/transfer of R31 from a shower chair to her bed, caused serious injury to the resident.	4 136		

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4 136	Continued From page 12 The facility's protocol for the use of the hoyer (Tempo) lift for transferring R31 on the early morning of 04/20/19 was to have been a two person assist. This was further verified by Registered Nurse (RN) 11, during her telephone interview on 09/12/19 at 01:58 PM. RN11 stated, "For the hoyer lifts, should be two people." However, this protocol was breached and not followed by CNA25. In addition, a lack of adequate supervision by RN11, who was the charge nurse on the night shift of 04/19/19 to 04/20/19, enabled CNA25 to perform an unsafe procedure using a mechanical lift, which in the end, caused a serious head injury to R31 from a drop/fall from the hoyer lift. 2) The FM interview revealed R31 was given an early morning shower on 04/20/19 and that, "it was 3:30-4:00 in the morning and that was the night shift . . ." Review of CNA25's witness statement found two versions, both dated 04/20/19 at 04:15 AM. One version revealed CNA25 completed R31's shower, brought the resident back to her room, ". . . while transferring the 2 upper attachment came off, the resident fell down with shower chair on the floor with hard impact to the head, noticed moderate bright red on the floor. I called charge nurse to come and assist." CNA25's second version stated, ". . .The resident was still in the shower chair and was able to do transfer using the hoyer lift. I set everything up, while transferring in the middle of lifting her up both upper attachment of the sling slipped off, I wasn't able to catch her, things happen so fast. the resident end up falling in the shower chair and hit her head by the shower chair. Immediately call the charge nurse."	4 136		

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4 136	Continued From page 13 During the DON's interview on 09/13/19 at 08:21 AM, she said as part of their fall prevention review, including a fall with injury, it involved looking at the root cause of the fall and communicating it back to her staff to prevent future falls. The DON was then queried if she asked CNA25 about one of the primary antecedent factors as a probable root cause, which was why the aide showered R31 by herself early that morning. The DON replied, "We felt this particular staff needed further training. We felt the use of the hoyer lift needed to be trained on. We could see this as a factor. We would report it as a near miss." However, review of CNA25's employee performance appraisal of 04/05/19 showed she exceeded expectations, including assisting residents with transfers and met expectations for the use of assistive devices, including a mechanical lift. The DON said the CNA's second version was probably written, "to clear some things up." However, the DON did not have a clear response regarding which version accurately depicted the events and cause of injury to R31. The DON stated, "a thorough investigation" had been done and multiple people helped her investigate this accident. The DON did say CNA25 explained it to her and that the shower chair was on the floor. After this statement, the DON was unable to provide any further response about the discrepancies in the two written statements submitted by CNA25. At the end of her interview, the DON said she would look at providing more information from others who conducted the investigation with her. On 09/13/19 at 10:35 AM, the DON stated she did not have any additional documentation	4 136		

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4 136	Continued From page 14	4 136		

regarding this investigation. The facility leadership failed to thoroughly investigate CNA25's unsafe use of an assistive device, her decision to shower the resident by herself, and failed to review the lack of documentation by the CNA.

(Of note, the State Survey Agency (SA) attempted to contact CNA25 and left two telephone messages, but to no avail. The facility was also asked to assist in contacting this CNA as well, but to no avail. Thus, the SA was unable to obtain a direct interview with her to further clarify the events leading up to R31's drop or fall from the hoyer lift with the resulting head injury.)

3) There was a lack of adequate supervision by the charge nurse, RN11, during the night shift of 04/19/19 into the morning of 04/20/19. During a telephone interview of RN11 on 09/12/19 at 01:58 PM, she said she was not aware of CNA25's whereabouts when the accident occurred. RN11 confirmed CNA25 was her only CNA staffed on the Mokihana unit that night and did not know CNA25 had taken R31 for an early morning shower. RN11 had been orienting a new nurse and CNA25 did not communicate that she was going to shower and transfer R31 by herself using the hoyer lift.

RN11 said as the charge nurse, she was responsible to know what was happening on the unit, including oversight of CNA25's actions. RN11 was not sure if the resident had, "made a mess or had to shower her right away," as the reason for the early morning shower. RN11 said again, "I know it's supposed to be two staff assist for the hoyer lift." She said, "I told (CNA25) it has to be two staff assist next time with me or whoever is the charge nurse." RN11 was queried

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4 136	Continued From page 15 if the hoyer lift was done with a two person assist, would this accident have been preventable, and she replied, "Yeah." R31 was showered early in the morning with no documented reason or knowledge as to why CNA25 was doing the shower and sole transfer. RN11 was asked if other residents were being showered in the early morning. RN11 said some of the other residents were receiving early morning showers, and was aware the CNAs would do these early morning showers. RN11 said she thought they should be documenting these early showers, but was unsure and stated, "I know they do the showers, but it could be to help out the day, but I don't know." RN11 said she worked with CNA25 after the accident but was uncertain whether CNA25 continued to shower residents early in the morning since she worked in the other buildings. 4) The facility's fall protocol stated the root cause analysis or "drill down" method was used to determine how/why a fall occurred. However, for R31's accident, one primary antecedent factor which preceded the accident was her early morning shower. Although the resident's daily shower schedule for 04/19/19 was requested, the Chief Nursing Officer (CNO) on 09/12/19 at 11:32 AM said per their DON, they did not have the daily shower schedule when R31 fell, "because it changes so often." The CNO was asked why her daily shower schedule would not have been kept as part of the facility's falls review/drill down method, to determine: 1) why such an early morning shower that resulted in a fall with injury occurred, and 2) why the CNA did it unsupervised and without the required two person assist. The CNO replied, "sometimes if they're soiled they might." The CNO was asked again whether this	4 136		

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4 136	Continued From page 16 was even reviewed, and the CNO stated she would check for a shower schedule during the time of the accident. This was not produced to the SA. 5) The facility's investigation failed to determine if the correct standard sling and type was used by CNA25 during R31's transfer. The DON verified it was the Tempo lift used on 04/20/19. Although she produced the facility's policy, "Mechanical Lift," Policy No. 1000003024, it had no effective date on it. The policy did state there were different types of slings with a color to match a size and if it was a transfer or bathing sling. The product description in Fig. 2 also showed the different sling profiles used with the Tempo lift. Yet, although CNA25 stated in both written versions that both upper attachments slipped/came off during the resident's transfer, the type of sling used and/or why the attachments came undone, was not investigated by the facility in determining how the accident occurred. 6) The facility failed to look at CNA25's documentation for 04/20/19, the morning of the accident. CNA25 failed to document the 04/20/19 early morning shower for R31. The shower entries showed a shower entry on 04/20/19 at 01:01 PM, which was after R31 returned from the hospital at 10:18 AM. The other shower entry was on the night of 04/19/19 and documented at 10:45 PM. There was no other shower entry for the early morning shower done before the accident happened or why it was given. This discrepancy and lack of clinical documentation by CNA25 was not investigated by the facility. During an interview with CNA8 on 09/12/19 at 03:24 PM, she reviewed the ADL Verification Worksheet and said for 04/20/19, the "4/2" meant	4 136		

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total assist with one person. CNA8 noticed the two shower entries and said if the resident was showered, although it may not be the real time of the shower, "you have to put it in before the end of your shift."

The shower entry of 04/19/19 at 10:45 PM may have been CNA25's entry, but then it meant it was documented before the shower was even given on the early morning of 04/20/19. Per CNA8, for the other shower entry, she said it was already, "the day shift" entry of the on-coming morning shift.

7) Record review also found CNA25 was counseled on 06/28/19 for using the hoyer lift by herself. CNA25's employee performance improvement plan (EPIP) stated the employee will use the hoyer lift with two staff assistance. Yet, her EPIP, dated more than two months after the accident, was found to be incomplete and invalid as it lacked the signatures and dates of CNA25, the supervisor, the human resources director and a witness. Although the DON said she counseled CNA25, she did not follow-up to check if CNA25 followed the hoyer lift protocol after she completed the initial one to one in-service with her on 04/26/19. The EPIP's "Follow-Up Dates & Results," was also blank and incomplete.

8) The facility failed to ensure after this accident, that all staff, including the registered nurse (RN) 11, who was the charge nurse on the 04/20/19 night shift, received the in-service education/training on the use of the hoyer lift. Of the approximate 21 licensed staff and 35 CNAs, only 12 other staff were in-serviced. Thus, approximately 1/5 or 21% of the nursing staff completed the 04/23/19 in-service education on

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4 136	Continued From page 18 "Transfers." In addition, the DON verified during her interview that she did not look at CNA25's lack of documentation and thus, did not provide any in-service education about inaccurate/incomplete documentation. The cumulative review found R31's head injury was avoidable based on the aforementioned findings. The facility leadership failed to thoroughly investigate how the accident occurred, and failed to implement measures to ensure residents who required transfers with mechanical lifts would be properly cared for. There also was a failure to ensure that adequate supervision and staffing needs were satisfactorily met, as no follow-up monitoring or documentation was provided to demonstrate what was done to prevent similar accidents from occurring by facility leadership. Cross-reference to findings at F725 and F726.	4 136		
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure there was	4 148	1. The home base for the night shift nurse will be the Mokihana unit. Night shift	10/22/19

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4 148	Continued From page 19 sufficient nursing staff to provide adequate supervision and care to prevent a potentially avoidable accident for one resident (Resident (R) 31). This deficient practice, including the lack of adequate supervision of CNA25 by the charge nurse that night, was a contributing factor for R31 sustaining serious injury and harm. This deficient practice also has the potential to cause serious harm to other residents residing in the facility, as the facility failed to complete their in-service education/training for hoyer lifts after the accident, and failed to monitor ADL activity/care provided to the residents during the night shift. In addition, another resident (R57) stated the facility lacked the staff to meet her toileting needs, and the resident council voiced there was not enough staff for the number of residents in the facility because of long wait times for assistance. This deficient practice had the potential to affect all residents residing in the facility. As such, the facility failed to ensure their staffing satisfactorily met the needs, care and services for their residents in order to have them maintain their highest practicable physical and psychosocial well-being. Findings Include: 1) There was a lack of nursing oversight and staffing for the Mokihana unit on 04/20/19. This lack of adequate supervision by the charge nurse, RN11, was revealed based on her telephone interview on 09/12/19 at 01:58 PM. RN11 stated that she was not aware of CNA25's whereabouts when R31's head injury occurred from a drop/fall from the hoyer lift. RN11 was the assigned charge nurse on the Mokihana unit on the night shift of 04/19/19 into 04/20/19. RN11 confirmed CNA25 was her only CNA	4 148	communication/supervision will be facilitated through the use of mobile communication devices. 2. Acuity levels of residents will be audited to ensure appropriateness of unit. Audited call light response times to ensure appropriate response times. Residents who are continent of bowel and bladder, and also cognitively intact, will be interviewed by Social Services Director or designee to ensure appropriate call light response times. 3. The home base for the night shift nurse will be the Mokihana unit. Night shift communication/supervision will be facilitated through the use of mobile communication devices. Acuity levels of residents will be monitored to ensure appropriateness of unit. 4. Audits of call light response times will be monitored by administrator or designee weekly x4 and monthly x2 thereafter. Call light response times will be added as a standing agenda item to be discussed during resident council meetings. Results of audits and resident council meetings will be referred to the QAPI committee for review and follow up as indicated.	

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4 148	Continued From page 20 staffed on the Mokihana unit that night and did not know CNA25 had taken R31 for an early morning shower. RN11 said as the charge nurse, she was responsible to know what was happening on the unit, including oversight of CNA25's actions. Because she did not know where or what CNA25 was doing, this was a contributing factor for R31 sustaining her head injury. By this lack of oversight of CNA25, it allowed CNA25 to perform a task (the early morning shower of R31) using the hoyer lift by herself and unsafely transfer R31. Further, RN11 was not sure if the resident had, "made a mess or had to shower her right away," as the reason for the early morning shower. There was no documentation found as to why CNA25 showered R31 that early in the morning. As to the appropriate use of the hoyer lift, RN11 stated, "I know it's supposed to be two staff assist for the hoyer lift." She said, "I told (CNA25) it has to be two staff assist next time with me or whoever is the charge nurse." RN11 was queried if the hoyer lift was done with a two person assist, would this accident have been preventable, and she replied, "Yeah." 2) RN11 also said some of the other residents were receiving early morning showers, and was aware the CNAs would do these early morning showers. RN11 said she thought they should be documenting these early showers, but was unsure and stated, "I know they do the showers, but it could be to help out the day, but I don't know." Yet, the facility's investigation of R31's accident did not include any inquiries or documentation of why an early morning shower was given to R31, or whether this was a practice by the night shift staff that was on-going, but unreported and undocumented.	4 148		

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4 148	Continued From page 21 3) RN11 stated for their night shift staffing in the Mokihana unit where R31 resides, they were staffed with one nurse and one CNA. She said the Mokihana charge nurse was also responsible for the care of the residents in the next building (Makalapua or "Maka"). RN11 said she went to the Maka unit whenever she got called to assess a resident. She said sometimes it would be an hour or so, depending on a resident's condition. RN11 said if she left Mokihana to go to Maka, it would leave the Mokihana residents with only one CNA. The Maka unit too, would be without a licensed staff once she would return to Mokihana. RN11 affirmed the staffing currently remains the same, and did not change after the 04/20/19 accident involving R31. RN11 stated the Ilima building/unit had their own nurse, and that nurse did not need to travel between the buildings. RN11 said she could not remember how many times she had to go to the Maka unit since the April incident. RN11 was asked if this was a safe practice to leave the Mokihana residents (or Maka residents) unattended and with one CNA, and she replied she did not think so. Of note, the daily staffing schedule showed the Maka unit was staffed with two night shift CNAs; however, on 04/25/19, the work schedule shows CNA25 worked the night shift on both the Mokihana and Maka units, which would have left one CNA in both buildings/units. 4) The potential for harm for the residents in Mokihana and Maka still exists since the facility failed to investigate and determine after R31's accident, if the night shift had been or still may be performing early morning resident showers, as well as one person assist transfers using the	4 148		

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4 148	Continued From page 22 hoyer lift, instead of the required two. Given the current staffing in the Mokihana and Maka buildings/units, if there was a need to use the hoyer lift, the Mokihana unit may not always have this capability, based on RN11's account of covering both buildings at any given time. On 09/13/19 at 10:32 AM, the DON produced the CNA in-service training log for CNA25 on the topic of transfers. The DON said, "it was verbal," and said she went over the hoyer lift in-service. DON verified she did not do any post incident monitoring or follow-up of CNA25 to show that staff were providing safe care using the hoyer lift. The DON verified she did not complete the staff in-service education/training on the hoyer lift and two person assist. The facility failed to show what was done to ensure the safety of all residents was being monitored for those who required the use of a mechanical lift for transfers. There was no documentation or evidence provided by the facility to show they performed any monitoring, such as on-site audits of staff involved in the accident and/or of other nursing staff. The facility also failed to determine whether their staffing sufficiently met the needs of the residents. During the DON's interview on 09/13/19 at 08:21 AM, she verified their staffing pattern did not change. She said only one nurse covers Mokihana and Maka for the night shift. The nurses worked a 12 hour shift, but the CNAs did not. She said the CNAs would switch out from the different buildings to help cover, but again, there was no documentation to show the allocation of staff, time and resources to verify their staffing was adequate to ensure the residents' needs were being met. Cross-reference to findings at F689 and F726.	4 148		

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4 148	Continued From page 23 5) On 09/11/19 at 08:52 AM, a follow-up interview was done with R57. She initially stated on the initial tour that the facility's staff took a while to answer her call light or toilet her when she needed to go. She said it happened on every shift. This interview revealed that R57 felt the facility has a lot of staff around, "but they all busy. The longest I waited was 20 minutes. When I want to use the bathroom, I just call, call, call and nobody comes you know." R57 said it happens frequently, and sometimes, "more than half an hour. I can't wait so I stand up, but I'm afraid you know." She reiterated that the wait time was usually was 20 minutes before staff could toilet her and it was, "anytime." She said even though they toilet her every two hours, she, "can't wait inbetween. I ring the bell at the bed and takes 20 minutes, sometimes longer. They have to hurry up, and sometimes the urine comes out, not much, just drops when I cannot hold." 6) During the Resident Council interview with the President and Vice President on 09/12/19 at 10:29 AM, the President stated that sometimes there were not enough staff for all of the residents in the facility. The President stated, "During these times several of the call lights are going on and the staff try to get to those residents but it takes a long time. As the president I alert the nurse if there is a resident who fell, or if someone needs help immediately. It isn't during any specific period of time during the day or night it happens at different times."	4 148		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following:	4 149		10/22/19

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4 149	Continued From page 24 (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on observation, record review, interview and policy review, the facility failed to ensure their nursing staff utilized the training, skills and knowledge to competently and safely care for one resident (Resident (R) 31) with adequate supervision and care. By failing to do so, R31 sustained a serious head injury from an accident involving the improper use of the hoyer lift along with no documentation for the reason an early morning shower was given to R31. This deficient practice, including the lack of adequate supervision of CNA25 by the charge nurse that night, was a contributing factor for R31 sustaining serious injury and harm. This deficient practice also has the potential to cause serious harm to	4 149	1. C.N.A. 25 has received documented remedial education regarding properly transferring Resident 31. 2. 90 day retrospective review of any hoyer lift related incidents was completed to identify any other residents who may have been affected by this practice. Appropriate action taken as necessary. 3. The home base for the night shift nurse will be the Mokihana unit. Night shift communication/supervision will be facilitated through the use of mobile communication devices. Education will be provided to night shift on proper utilization of mechanical lift transfers and	

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4 149	Continued From page 25 other residents residing in the facility, as the facility failed to complete their in-service education/training for hoyer lifts after the accident, and failed to monitor the competence of their staff in the delivery of care provided to the residents during the night shift. Findings Include: 1) R31 sustained a serious head injury on 04/20/19 due to CNA25 not following the hoyer lift two person assist protocol. Cross-reference to findings at F689 and F725. The resident's family member (FM) stated they found out that R31 was showered early in the morning around 3:30-4:00 AM by one staff (CNA25), and had fallen out of the hoyer lift during the transfer. The FM stated the nurses told her it should have been a two person transfer. 2) It was found that CNA25 had received in-service education on the use of a mechanical lift prior to the 04/20/19 accident. This was verified by the Director of Nursing (DON) on 09/13/19 at approximately 12:10 PM, when she produced CNA25's 12 hour in-service education sheet. The DON confirmed CNA25 received this training on 04/08/19, which was included in their topic, Safety & Body Mechanics. The mechanical lifts, including the hoyer lift, was a two person assist to ensure safe transfer of a resident. Yet, it was found that CNA25 did not follow this basic safety protocol, and by performing a single person assist to transfer R31 from a shower chair to her bed, caused serious injury to the resident. The facility's protocol for the use of the hoyer (Tempo) lift for transferring R31 on the early morning of 04/20/19 was to have been a two person assist. This was further verified by	4 149	documentation of showers provided on night shift 4. DON or designee will conduct audits through direct observation on proper mechanical lift transfer technique. Retraining and reeducation will be done as necessary. Audits will be done weekly x4 and monthly x2 thereafter. Results of audits will be referred to the QAPI committee for review and follow up as indicated.	

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4 149	Continued From page 26 Registered Nurse (RN)11, during her telephone interview on 09/12/19 at 01:58 PM. RN 11 stated, "For the hoyer lifts, should be two people." Because this protocol was breached and not followed by CNA25, and without adequate supervision by RN11, who was the charge nurse on the night shift of 04/19/19 to 04/20/19, staff's failure to follow a safe, standard procedure using a mechanical lift allowed the events to occur, which was R31's drop/fall from the hoyer lift with a subsequent head injury. RN11 said as the charge nurse, she was responsible to know what was happening on the unit, including oversight of CNA25's actions. RN11 was not sure if the resident had, "made a mess or had to shower her right away," as the reason for the early morning shower. RN11 said, "I know it's supposed to be two staff assist for the hoyer lift." She said, "I told (CNA25) it has to be two staff assist next time with me or whoever is the charge nurse." RN11 was queried if the hoyer lift was done with a two person assist then, if this accident would have been preventable, and she replied, "Yeah." 3) The facility's investigation failed to determine if the correct standard sling and type was used by CNA25 during R31's transfer. The DON verified it was the Tempo lift used on 04/20/19. Although she produced the facility's policy, "Mechanical Lift," Policy No. 1000003024, it had no effective date on it. The policy did state there were different types of slings with a color to match a size and if it was a transfer or bathing sling. The product description in Fig. 2 also showed the different sling profiles used with the Tempo lift. Yet, although CNA25 stated in both written versions that both upper attachments slipped/came off during the resident's transfer,	4 149		

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4 149	Continued From page 27	4 149		

the type of sling used and/or why the attachments came undone, was not investigated by the facility in determining how the accident occurred.

4) The facility failed to look at CNA25's documentation for 04/20/19, the morning of the accident. CNA25 failed to document the 04/20/19 early morning shower for R31. The shower entries showed a shower done on 04/20/19 at 01:01 PM which was after R31 returned from the hospital at 10:18 AM. The other shower entry was on the night of 04/19/19 and documented at 10:45 PM. There was no other shower entry for the early morning shower done before the accident happened. This discrepancy and lack of clinical documentation by CNA25 was not investigated by the facility, nor were her competency skills re-examined by follow-up monitoring after R31's accident.

5) Record review also found CNA25 was counseled on 06/28/19 for using the hoyer lift by herself. CNA25's Employee Performance Improvement Plan (EPIP) stated the employee will use the hoyer lift with two staff assistance. Yet, her EPIP, dated more than two months after the accident, was found to be incomplete and invalid as it lacked the signatures and dates of CNA25, the supervisor, the human resources director and a witness. Although the DON said she counseled CNA25, she did not follow-up to check if CNA25 followed the hoyer lift protocol after she completed the initial one to one in-service with her on 04/26/19. The EPIP's "Follow-Up Dates & Results," was also blank and incomplete.

6) The facility failed to ensure after this accident, that all staff, including the registered nurse (RN)11, who was the charge nurse on the

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4 149	Continued From page 28 04/20/19 night shift, or the new nurse orientee, RN57, received the in-service education/training on the use of the hoyer lift. Of the approximate 21 licensed staff and 35 CNAs, only 12 staff were in-serviced. Thus, approximately 1/5 or 21% of the nursing staff completed the 04/23/19 in-service education on "Transfers." The DON verified during her interview on 09/13/19 at 08:21 AM, that she did not look at CNA25's missing documentation about the early morning shower. The DON said thus she did not provide any in-service education about inaccurate/incomplete documentation. The facility's investigation supplement revealed entries by the interdisciplinary team (IDT) done after the 04/20/19 accident. The IDT review for follow-up was to ensure there was to be two staff assisting with all hoyer lift transfers, ensure the sling was the appropriate size and attached correctly to the hoyer lift, and for staff training to be done, with two staff present using the hoyer lift. However, there were no additional competency records or documentation to show these measures were started and monitored to assure a safe environment of care was maintained for their residents	4 149		
4 198	11-94.1-46(o) Pharmaceutical services (o) A pharmacist shall, on a monthly basis, review the record of all residents receiving medications to determine potential adverse reactions, interactions, and contraindications. The review and any concerns identified shall be documented in the resident's record.	4 198		10/22/19

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4 198	Continued From page 29 This Statute is not met as evidenced by: Based on record review (RR) for one of five Residents (R) reviewed R34 was prescribed an anti-anxiety medication as needed (PRN) for greater than two weeks. This deficient practice with the lack of monitoring has the potential of having detrimental side effects for the resident by not keeping her free from unnecessary medications. Findings Include: Minimum data set (MDS) quarterly review dated 07/19/19 was reviewed for R34. She is diagnosed with Anxiety Disorder and Depression. Section V care area assessment was coded for mood and psychotropic drug use. Orders reviewed dated 07/26/19: Monitor behavior every (Q) shift for lorazepam (an anti-anxiety) use two times daily (BID). For Lorazepam use. Behavior: Picking at skin with tweezers. Monitor Side effects: Dizziness, drowsiness, lethargy, apnea. Medication Administration Record, (MAR) for R34 reviewed: 1. Starting 08/13/19, Lorazepam 0.5 milligram (mg) tablet, give 1 tablet via gastrostomy tube (G-tube) as needed two times continue for 2 weeks. Pharmacy notes reviewed: Medication Regimen Review (MRR) dated 10/22/18 reviewed. PRN psychotropic orders cannot exceed 14 days with the exception that the prescriber documents their rationale in the residents medical record and indicate the duration for the PRN order. Please consider. There were no new orders for the PRN	4 198	1. DON or designee appropriately renewed Resident 34□s medication order for Lorazepam. 2. Audit completed on other residents with PRN anti-anxiety medications to ensure orders are appropriately renewed. 3. Education will be provided to nursing staff and Resident 34□s physician on requirement to renew medication orders of PRN anti-anxiety medications timely. 4. DON or designee will conduct audits of residents receiving PRN anti-anxiety medications to ensure orders are appropriately renewed. Audits will be done weekly x4 and monthly x2 thereafter. Results of audits will be referred to the QAPI committee for review and follow up as indicated.	

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4 198	Continued From page 30 anti-anxiety. MRR for following dates reviewed: 03/16/19, 05/15/19, 06/11/19, 07/91/19, 08/07/19, no new suggestions. Behavior team rounds notes dated 09/06/19 reviewed: Medications include Lorazepam (an anti-anxiety) 0.5 mg prn BID via G-Tube; Zolpidem 10 mg via G-tube prn headache; Melatonin 5 mg via G-tube. PRN at bedtime. "Resident is doing well on prn Melatonin with other medications. Next evaluation recommended in 3 months. No changes." During an interview with Registered Nurse (RN)54 on 09/13/19 at 1:00 PM, she stated that R34 is on Lorazepam PRN, adding that R34 takes the medication twice per day even though it is ordered PRN. She agreed that the medication order is longer than two weeks and will follow up with the MD for a new order. Normally the MD will review the pharmacist recommendations and follow up with the orders. R34 behavior rounds were changed from monthly rounds to quarterly rounds.	4 198		